UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
(SAN FRANCISCO DIVISION)

IN RE: VIAGRA (SILDENAFIL CITRATE) AND CIALIS (TADALAFIL) PRODUCTS LIABILITY LITIGATION	Case No. 16-md-02691-RS MDL No. 2691
This Document Relates to: ALL ACTIONS	**[JOINT ~~PROPOSED~~] PRETRIAL ORDER NO. 15: PLAINTIFF FACT SHEETS, RESPONSIVE DOCUMENTS AND AUTHORIZATIONS**

This Order concerns the completion and execution of Plaintiff Fact Sheets, the initial production of documents by Plaintiffs, and the execution of related Authorizations for the release of records. The Parties agree that the use of such discovery devices will assist in furthering the proceedings. Accordingly, each Plaintiff shall prepare and execute Plaintiff Fact Sheet(s), shall produce documents and shall execute Authorizations in accordance with this Order.

1. **Scope of Order.** This Order governs the completion and execution of Plaintiff Fact Sheets

("PFS"), initial production of documents, and the execution of Authorizations for the release of records to be completed by Plaintiffs. This Order shall govern the cases: (1) transferred to this Court by the Judicial Panel on Multidistrict Litigation ("JPML"), pursuant to its Order(s) of April 7, 2016 and December 7, 2016; (2) transferred to this Court by the JPML pursuant to Rule 7.4 of the Rules of Procedure of that Panel; or (3) directly filed in this Court, transferred or properly removed to this Court. This Order is binding on all parties and their counsel in all cases currently pending or subsequently made a part of these MDL Proceedings and shall govern each case in the proceedings.

Nothing in the PFS shall be deemed to limit the scope of inquiry at depositions or the admissibility of evidence at trial. The scope of inquiry at depositions shall remain governed by the Federal Rules of Civil Procedure. The admissibility of information provided in responding to

the PFS shall be governed by the Federal Rules, and no objections are waived by virtue of any PFS response.

2. **Service of PFSs, Responsive Documents and Authorizations.** Each Plaintiff shall complete and serve upon Defendants a PFS, in the form attached as Exhibit 1, the documents requested in Section VIII of the PFS ("the Responsive Documents"), and the relevant Authorizations for the release of records in the forms attached as Exhibits 2–8 ("the Authorizations"). Plaintiffs shall serve the PFSs, the Responsive Documents and the Authorizations, on the schedule set forth in paragraph 5 of this Order, in a manner to be set forth in a subsequent order.

3. **Signature of PFS and Amendments by Plaintiff(s).** All responses in a PFS or an amendment thereto are binding on the Plaintiff(s) as if they were contained in responses to interrogatories, and must be supplemented according to Federal Rule of Civil Procedure 26(e). Each PFS and amendment thereto shall be signed and dated by the Plaintiff or, if the Plaintiff is incapacitated, the proper legally appointed Plaintiff representative, under penalty of perjury.

4. **Execution and Use of Authorizations.**

a. **Execution of Authorizations Generally.** Plaintiffs shall either (1) provide individual executed Authorizations for providers and facilities identified in the PFS or (2) date and sign the Authorizations without setting forth the identity of the applicable custodian of the records or provider of care (these are referred to herein as "blank" Authorizations). Plaintiffs who provide individual executed Authorizations for providers and facilities identified in the PFS, instead of blank Authorizations, shall in addition provide to Plaintiffs' counsel, at the time that Plaintiffs' completed PFS is served, blank Authorizations sufficient in number for later potential use as set forth in paragraph 4.c. herein, so that Plaintiffs' counsel may meet the response time obligations set forth in that section.

b. **Authorizations to be Provided.**

i. **Medical Authorizations.** Each individual Plaintiff shall serve originals of the "Limited Authorization to Disclose Health Information" attached as Exhibit 2 for each individual healthcare provider identified in the PFS, or a blank authorization. If a Plaintiff is asserting a claim for psychological injury or has identified a mental health provider or counselor on his or her PFS in response to relevant questions, such Plaintiff shall also complete the Authorization attached as Exhibit 3 for the specific providers identified in the PFS. If a Plaintiff is not asserting a claim for psychological injury, Plaintiff does not need to complete the Authorization attached as Exhibit 3.

ii. **Employment Authorizations.** Each individual Plaintiff who has been employed at any time from 10 years prior to melanoma diagnosis to present and is also making a claim for lost wages shall execute the Authorization for the release of employment records, in the form attached as Exhibit 4.

iii. **Insurance Authorizations.** Each individual Plaintiff who has had health insurance in the 5 years prior to the diagnosis with melanoma to the present shall execute an Authorization for the release of insurance records, in the form attached as Exhibit 5 for each effective policy. If the Plaintiff has been covered by Medicare at any time during the 5 years prior to the diagnosis with melanoma to the present, Plaintiff shall also complete the Authorization for the release of Medicare records, in the form attached as Exhibit 6.

iv. **Workers' Compensation and Disability Authorizations.** If a Plaintiff has filed for workers' compensation or disability benefits, such Plaintiff shall execute the Authorization for the release of workers' compensation records, in the form attached as Exhibit 7, and/or the Authorization for the release of disability records, in the form attached as Exhibit 8, as applicable. If a Plaintiff has not filed for either workers' compensation or disability, that Plaintiff need not complete either Authorization.

v. **Obligation to Cooperate by Providing Additional Authorizations**. If a custodian of records who was listed in the PFS, or who was identified to Plaintiff's Counsel pursuant to the procedures set forth in Section 4.c.ii below, will not accept the authorizations Plaintiff has submitted,

Plaintiff will cooperate with Defendants and provide the necessary authorization(s) for identified providers and facilities.

c. **Defendants' Use of Authorizations.**

i. **Records Custodians Listed in the PFS.** Defendants may use the provided Authorizations to obtain records from the particular custodians identified on the Authorizations, or from any custodian of records listed in the PFS if a blank Authorization was provided by Plaintiff, without further notice to Plaintiff's counsel.

ii. **Records Custodians Not Listed in the PFS**. For any custodian of records not listed in the PFS, Defendants may use the blank Authorizations (if provided by Plaintiff) to obtain records by providing Plaintiffs' Counsel notice of its intent to do so via email fourteen (14) days before sending the Authorization to the custodian of record ("the notice period"). If Plaintiff's counsel fails to object within the notice period, Defendants may use the Authorization to request the records from the source identified in the notice. If Plaintiff's counsel objects to the use of the Authorization to obtain records from the source identified in the notice within the notice period, Plaintiff's counsel and Defendants' counsel shall meet and confer in an attempt to resolve the objection. If counsel are unable to resolve the objection, Plaintiff shall file a motion for a protective order within twenty-eight (28) days of the Defendants' notice of intent to use the Authorization.

For any custodian of records not listed in the PFS, if blank Authorizations have not already been provided by Plaintiff, Defendants may request that Plaintiff's counsel complete an Authorization, either blank or fully executed for the requested custodian, so that Defendants may obtain records from that custodian. Plaintiffs' counsel must provide such authorizations within fourteen (14) days of the written request. If Plaintiffs' counsel objects to the use of the Authorization to obtain records from the source identified in the request, Plaintiffs' counsel must assert that objection within fourteen (14) days. Following the 14-day period, if Plaintiffs' counsel objects or has not responded, Plaintiffs' counsel and Defendants' counsel shall meet and confer in an attempt to resolve the objection. Defendants' counsel shall also notify Plaintiffs' designated PSC fact sheet counsel. If counsel are unable to resolve the objection, or if Plaintiffs' counsel does not respond to Defendants' attempt to meet and

confer, Defendants may file a motion to compel Plaintiffs' counsel shall have fourteen (14) days to file any opposition.

d. **Production of Records Obtained by Authorizations.** Defendants' counsel shall make records received pursuant to the Authorizations available to Plaintiff's counsel at Plaintiff's request and at cost to Plaintiff, in a manner to be set forth in a subsequent order

5. **Deadline for PFSs, Authorizations, and Responsive Documents.**

a. **Northern District of California Resident Cases Currently in MDL Proceedings.** All Plaintiffs who reside within the Northern District of California and whose cases are currently part of these MDL Proceedings must serve Defendants with PFSs, Responsive Documents and Authorizations within or not later than one hundred twenty (120) days of entry of this order.

b. **Remaining Cases Pending in MDL Proceedings**. All Plaintiffs whose cases are currently part of these MDL Proceedings, and who are not included among the Plaintiffs discussed in paragraph a, must serve Defendants with PFSs, Responsive Documents and Authorizations within or not later than one hundred fifty(150) days of entry of this order.

c. **Cases Later Made Part of MDL Proceedings.** For any Plaintiff whose case is not currently part of these MDL Proceedings as of the date of this Order, but whose case is later filed in, transferred to, removed to, or reassigned to this Court and thereby made part of these MDL Proceedings, such Plaintiffs must serve Defendants with a complete and verified PFS, Responsive Documents, and completed Authorizations within the following time limits: (1) if Plaintiff's case is filed directly in the Northern District of California, within one hundred twenty (120) days from the date filed; or (2) if Plaintiff's case is filed outside the Northern District of California and later transferred or removed to this Court, within thirty (30) days from the date the short form complaint is filed in this Court..

6. **Grace Period for Delinquent Plaintiffs.** Plaintiffs who fail to provide a complete and verified PFS, Responsive Documents, and execute Authorizations within the time periods set forth above shall be given notice by e-mail from Defendants' Counsel of all deficiencies, copying Plaintiffs' designated PSC fact sheet counsel, and shall be given thirty (30) additional days to cure such deficiency.

If a Plaintiff does not cure the deficiency within that period of time, Defendants may move the Court for an Order dismissing such Plaintiff's Complaint without prejudice. Plaintiff shall have thirty (30) days from the date of Defendants' motion to file a response either (1) certifying that Plaintiff has served upon Defendants, and Defendants have received, a completed PFS, and attaching appropriate documentation of receipt, or (2) opposing Defendants' motion. If a Plaintiff timely files such a response, his or her claims shall not be dismissed.

Upon entry of an Order of Dismissal without Prejudice, Plaintiff shall have thirty (30) days to serve Defendants with a completed PFS or move to vacate the dismissal. If Plaintiff fails to serve Defendants with a completed PFS or move to vacate the dismissal within thirty (30) days, the Order will, upon Defendants' motion, be converted into an Order of Dismissal with Prejudice.

7. **Additional Discovery Permitted.** Defendants' use of the PFS, Responsive Documents, and Authorizations shall be without prejudice to Defendants' right to serve additional discovery at a later time, to be determined according to this Court's subsequent orders.

SO ORDERED.

Dated: 11/30/18

THE HONORABLE RICHARD SEEBORG
UNITED STATES DISTRICT JUDGE

EXHIBIT 1

Plaintiff Fact Sheet

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

MDL No. 2691
In Re: Viagra (Sildenafil Citrate) and Cialis (Tadalafil) Products Liability Litigation

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Instructions

Please answer every question to the best of your knowledge. In completing this Plaintiff Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all the details requested, please provide as much information as you can or otherwise indicate that you cannot recall. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect. For each question where the space provided does not allow for a complete answer, please attach additional sheets so that all answers are complete.

If you are asked to identify a person (such as doctors or witnesses), please provide the name and last-known address and telephone number.

Definitions

PLAINTIFF, YOU OR YOUR: The individual who allegedly took Viagra, Revatio, Cialis and/or Adcirca.

VIAGRA/REVATIO: These two drugs are part of a class of drugs known as PDE5 inhibitors. The active ingredient in both is sildenafil and the manufacturer is Pfizer Inc.

CIALIS/ADCIRCA: These two drugs are part of a class of drugs known as PDE5 inhibitors. The active ingredient in both is tadalafil and the manufacturer is Eli Lilly & Co.

TREATING HEALTHCARE PROVIDERS: Any provider of healthcare, including but not necessarily limited to physicians, general practitioners, medical specialists, medical doctors, surgeons, plastic surgeons, nurses, nurse practitioners, physician assistants, rehabilitation specialists, physical therapists, occupational therapists, counselors and pharmacists.

SERIOUS ILLNESS: A serious illness is a condition that involves one or more of the following: hospital care; a period of incapacity lasting three or more consecutive days; pregnancy; chronic conditions requiring continued or repeated treatments; permanent/long-term conditions requiring supervision and/or multiple treatments for a non-chronic condition.

PLAINTIFF FACT SHEET

PLAINTIFF'S FULL NAME: _____

I. CASE INFORMATION

A. Please state the following for the lawsuit that you filed:

Case Caption:
MDL Case Number: _____

Plaintiff's Attorney Name:
Firm Name:
Plaintiff's Attorney Address:
E-Mail Address:
Phone Number:

B. Representative: If you are completing this questionnaire in a representative capacity (e.g., on behalf of the estate of a deceased person), please complete the following:

Name of Decedent	Decedent's Street Address at Time of Decedent's Death	In what capacity are you representing the Decedent?

1. **Representative Information.**

Name, and Current Address	Relationship to the Deceased	Court Case Number and Date of Appointment (if applicable)

II. PERSONAL INFORMATION FOR PLAINTIFF

A. Background.

Your Full Legal Name: _____
Other Names, Nicknames, and Aliases, if any, and the date(s) of such use:
_____
Social Security Number: _____
Date and Place of Birth: _____
Plaintiff's date of death, place of death and cause of death, if applicable:
_____

B. Marital Status.

1. Current Marital Status (choose one):

☐ Never married ☐ Legally married and living together

☐ Legally married, but separated ☐ Common law union

☐ Divorced ☐ Widowed

2. Marital History. If Plaintiff has ever been married, whether legally or as a common law marriage, please provide the following for each marriage:

Spouse's Name and Any Other Name Used By Spouse	Spouse's Date of Birth and, if applicable, Date of Death	Spouse's Current or Last Known Address (if known)	Dates of Marriage and Any Legal Separation, Divorce, or Annulment

C. Residence(s). Identify each state of residence where (i) you have lived from ten (10) years prior to melanoma diagnosis until the present, and (ii) you lived prior to the age of twenty (20).

Address	Dates of Residence

Please list the complete current address (if deceased, last address):
Street: _____
City, State, Zip Code: _____
Dates of Residence: _____

D. Outdoor Activities.

1. Provide the following information about regular outdoor activity, including any specific exercise(s), sports (for example, golf, fishing, tennis, cycling, skiing, running, boating, surfing), vocational (for example, truck driving, lifeguarding, construction working, farming), recreational, or domestic activities (for example, gardening, mowing the lawn), that you have engaged in between ten (10) years prior to melanoma diagnosis until the present:

Activity	Average Annual Frequency (please state: 1-5 days/year, 6-10 days/year, or more than 10 days/year)	Dates/Time Period	Location of Activity (gym, at home, playing field, etc.)

2. Have you owned any of the following?:

Convertible	Yes ☐ No ☐
Boat	Yes ☐ No ☐
Motorcycle	Yes ☐ No ☐
Jet ski / Personal watercraft	Yes ☐ No ☐
All-terrain vehicle (ATV)	Yes ☐ No ☐

E. Vacations. Provide the following information for vacations taken by you dating back to ten (10) years before your diagnosis with melanoma. Please include any secondary homes, including vacation homes and/or long-term or recurrent seasonal homes you had before your melanoma diagnosis to the present:

Location	Length of Vacation	Vacation Dates	Vacation Activity (e.g., beach, golf, hiking)

F. Complexion of Plaintiff.

Natural Hair Color: Blond ☐ Red ☐ Light Brown ☐ Dark Brown ☐ Black ☐
☐ Other (please describe):
Natural Eye Color: Blue ☐ Gray ☐ Green ☐ Hazel ☐ Brown ☐
☐ Other (please describe):
Natural Skin Color: Pale White ☐ White ☐ Light Brown ☐ Dark Brown ☐
☐ Other (please describe): _____

G. Dermatological History. Please indicate, to the best of your knowledge, whether you have ever experienced any of the following and the frequency of each:

	Experienced (Y/N)	**Number/Frequency**	**Age(s)/Date(s) Experienced**
Moles on Arms, Face, Neck, Head, Torso, Legs			
Freckling of Skin			
Moles Larger than 5mm in Diameter			

H. Race/Ethnicity. Because many diseases and conditions may be more or less prevalent in certain racial and ethnic groups, please identify your racial and ethnic background:
American Indian ☐ Asian ☐ Black/African-American ☐ Latino ☐ White ☐
☐ Other (please describe): _____

I. Education History. Identify any post high school education such as a vocational school, college, university or other post-secondary educational institution you have attended, the dates of attendance, and any diplomas or degrees awarded (if any).

School	**Dates of Attendance**	**Diplomas/Degree Awarded**

J. **Employment History.** Provide the following information regarding your employment, ***including self-employment*** from ten (10) years prior to melanoma diagnosis until present. ***If you are making a claim for lost wages in this case, also list, for each position, salary, annual gross compensation and/or other compensation received***.

Employer's Name, Supervisor, Address, Telephone Number	Dates of Employment	Occupation / Title	Reason for Leaving	Salary / Annual Gross Income (Only Complete if making a Lost Wages Claim)	Out of Work for More than 30 Days for Medical Reasons (excluding any mental health related illnesses)? YES or NO

K. **Military Service**.

Have you ever served in any branch of the military? Yes ☐ No ☐

If yes, provide branch and dates of service: _____

L. **Other Lawsuits.** If you have ever been a party to an arbitration or civil lawsuit, other than the present action, related to your use of any PDE5 inhibitor use and/or melanoma, please provide the following to the extent it is known:

Caption and Case Number	When and Where Filed	Nature of Claims Including Any Personal Injury Claims	Attorney and/or Law Firm Representing You	Outcome (Verdict, Arbitration Settlement or Dismissal)

M. Criminal History. In the past 10 years, have you been convicted of or pled guilty to any felony (crime punishable by imprisonment for more than one year) or any crime involving dishonesty and/or false statements? (Excluding any charges or other sealed records if you were under the age of majority.)**?**

Yes ☐ No ☐ If yes, please list the crime or offense, the county, the state, the Court and outcome, including the date of any conviction or guilty plea.

_____

_____

N. Claims. Please identify any worker's compensation, social security, bankruptcy, or disability claims you have filed.

Case Name or Caption	Date Filed	Type of Claim (worker's comp, bankruptcy, social security, disability)	Resolution / Outcome

III. TREATMENT FOR ERECTILE DYSFUNCTION, PULMONARY ARTERIAL HYPERTENSION, AND BENIGN PROSTATIC HYPERPLASIA

A. Viagra/Revatio/Cialis/Adcirca Use.

1. For what condition(s) were you prescribed Viagra, Revatio, Cialis and/or Adcirca (*e.g.*, erectile dysfunction, pulmonary arterial hypertension, benign prostastic hyperplasia)? _____

2. When were you first diagnosed with this condition? _____

3. **Other Treatments of Erectile Dysfunction, Pulmonary Arterial Hypertension, or Benign Prostatic Hyperplasia**. Have you ever used any other PDE5 inhibitor (excluding Viagra, Revatio, Cialis and/or Adcirca) or other medications for the treatment of erectile dysfunction or pulmonary arterial hypertension or benign prostatic hyperplasia (for example: non-oral medications such as implants, pumps, injections, or supplements; Levitra, Staxyn, Stendra, Spedra, Edex, Flolan, Veletri, or other vasodilators; Tracleer or other endothelin receptor antagonists; Flomax or other alpha blockers; Avodart or other 5-alpha reductase inhibitors)? Complete the following for all other medications.

Medication Used	NDC Code (if known)	Dates of Use	Dose and Frequency of Use (for example: once a week, once a month)	Prescribing Healthcare Provider(s) and Address	Reason Prescribed

4. At any time, did you request that any doctor or clinic prescribe to you Viagra, Revatio, Cialis and/or Adcirca? Yes ☐ No ☐

   If yes, please complete the following:

5. When did you make this request: _____

6. To whom did you make this request: _____

7. Please fill out the below table about your use of Viagra, Revatio, Cialis and/or Adcirca:

Medication Used	Dates of Use	Dose and Frequency of Use (for example: once a week, once a month)	Prescribing Healthcare Provider(s) and Address	Name and Address of Pharmacy Filled At

8. Have you ever received any samples of Viagra, Revatio, Cialis and/or Adcirca?
Yes ☐ No ☐ Do Not Recall ☐
If yes, please complete the following:

Medication Received as Sample	Date Sample Received	Provider of Sample	Number of Samples Received	Were Samples Consumed?

9. At any time, did you receive any written and/or oral information, including but not limited to instructions or warnings, about Viagra, Revatio, Cialis and/or Adcirca?
Yes ☐ No ☐

If yes, please complete the following:

a. Information received:

_____

_____

b. Whether the information was written or oral: _____

c. When you received the information:

_____

d. From whom you received the information:

_____

(Please copy and complete and attach additional pages if necessary to provide a complete response.)

IV. ALLEGED INJURY AND DAMAGES

A. Alleged Injuries. For each injury you claim to have sustained as a result of ingesting Viagra, Revatio, Cialis and/or Adcirca, provide the following information (regardless of the date on which you associated the injury with the ingestion of the specific drug):

Injury Type / Medical Condition	Date First Aware of Symptoms / Injury	Name and Address of Healthcare Provider(s) Who Diagnosed Injury	Date of Diagnosis

B. Melanoma. Provide the following information for each diagnosis of melanoma:

Melanoma Date of Diagnosis	Location on the Body	Breslow Depth or Melanoma Stage

C. Treatment Completed, Ongoing, or Planned. Provide the following information about each treatment undertaken, scheduled, or that is planned for the future to treat any of the injuries alleged above:

Type of Treatment Received / Planned	Name and Address of Healthcare Provider(s) and/or Surgeons Who Treated / Will Treat Injury	Date of Treatment (including past, present, and future planned)	Were you Hospitalized? (Y/N)	If Hospitalized, Name and Address of Hospital	Date(s) of Hospitalization
					s

D. Emotional Injury. Are you claiming a mental and/or emotional condition as a consequence of your melanoma diagnosis as it relates to your use of Viagra, Revatio, Cialis and/or Adcirca? Yes ☐ No ☐

If yes, please provide the following information for any conditions since your melanoma diagnosis:

Condition	Type of Treatment (If Medication, Include Name)	Name/Address of Healthcare Provider(s) Who Treated / Will Treat Injury	Date(s) of Treatment

E. **Medical Expenses**. Are you seeking recovery for any out-of-pocket expenses associated with your use of Viagra/Revatio/Cialis/Adcirca and/or the health condition you allege you suffered as a result of such use? Yes_____ No_____

F. **Discussions with Healthcare Providers.** Have you had discussions with any treating healthcare provider(s) about whether your melanoma is related to Viagra, Revatio, Cialis and/or Adcirca? Yes ☐ No ☐

1. If yes, complete the following:

Check all of the following that apply and identify the provider with whom each conversation took place:

☐ I was told by provider(s) _____ that my condition is related to Viagra/Revatio/Cialis/Adcirca.

☐ I was told by provider(s) _____ that my condition is not related to Viagra/Revatio/Cialis/Adcirca.

☐ I was told by provider(s) _____ that my condition may be related to Viagra/Revatio/Cialis/Adcirca.

☐ I was told by the provider(s) _____ that he or she does not know whether my condition is related to Viagra/Revatio/Cialis/Adcirca.

☐ I don't recall what I was told.

☐ Other (describe discussion regarding Viagra, Revatio, Cialis and/or Adcirca) __

_____

2. For each healthcare provider listed above, please complete the following:

Healthcare Provider	Address	Healthcare Provider's Specialty (if known)	Date of Discussion

G. Computer Use.

1. To the best of your recollection, did you visit within the past five (5) years any website containing information regarding Viagra, Revatio, Cialis, or Adcirca; erectile dysfunction and/or its treatments; pulmonary arterial hypertension and/or its treatments; benign prostastic hyperplasia and/or its treatments; skin cancer; and /or melanoma? **Yes ☐ No ☐ Cannot Recall ☐**

If yes, please complete the following:

Website Name or Internet Address	Date(s) Visited

2. During the period from five (5) years prior to melanoma diagnosis to the present, did you publicly post a comment, message or blog entry on a public internet site or chat room regarding Viagra, Revatio, Cialis, Adcirca, other PDE5 inhibitors, erectile dysfunction and/or its treatments, pulmonary arterial hypertension and/or its treatments, benign prostastic hyperplasia and/or its treatments, skin cancer, and/or melanoma? (You should include all postings on public social network sites including Twitter, Facebook, MySpace, LinkedIn, or "blogs" where the general public may post such comments). **Yes ☐ No ☐ Cannot Recall ☐**

If yes, please complete the following:

Location of Post	Date(s) of Post

H. Communications with Pfizer and/or Eli Lilly. Provide the following information about any communication(s) between Plaintiff or anyone acting on his/her behalf with any employee, agent, or representative of Pfizer and/or Eli Lilly specifically regarding or related to Viagra, Revatio, Cialis and/or Adcirca (excluding communications between attorneys since the filing this lawsuit).

Person With Whom Communicated	Date of Communication	Form of Communication (e.g. email, phone call, letter)	Substance of Communication

V. PLAINTIFF'S MEDICAL BACKGROUND

A. Medical Conditions. Provide the following information about your experience, if any, with the medical conditions below.

Medical Condition	Experienced? (Y/N)	Date of Onset	Date of Diagnosis	Treating Healthcare Provider(s)	Treatment Provided	Current Status
Actinic or Solar Keratosis						
Atypical or Abnormal Mole Removal						
Non-Hodgkin's Lymphoma						
T-Cell Lymphoma						
Chronic Lymphocytic Leukemia (CLL)						
Basal Cell Carcinoma						
Squamous Cell Carcinoma						

B. UV Exposure. Please indicate, to the best of your knowledge, whether you have ever experienced any of the following and the frequency of each:

Event	Experienced? (Y/N)	Frequency? (number of times experienced or used)	Age(s)/Date(s) Experienced
Sunburn			
Blistering Sunburn			
Tanning Bed or Sun Lamp Use			
Sunscreen Use			

C. **Genetic Testing.** Have you ever had genetic testing for mutations in the following genes:

BRAF Yes ☐ No ☐
CDKN2A Yes ☐ No ☐
CDK4 Yes ☐ No ☐
NRAS Yes ☐ No ☐

Have you had any other genetic testing (specify type): _____

If yes for any, describe outcome of test results (e.g., positive or negative, mutation(s) identified, or other diagnostic or genetic information reported):

_____

D. **Family Medical History.** Please indicate whether, to the best of your knowledge, your *parents, siblings, children,* or *grandparents* have experienced, been diagnosed with or treated for any of the following health conditions:

Medical Condition	Y/N	Date(s) of Onset	Relationship(s) to Plaintiff	Current Status (Recovered/Still treating/ Cause of death)
Non-Hodgkin's Lymphoma				
T-Cell Lymphoma				
Chronic Lymphocytic Leukemia (CLL)				
Melanoma				
Basal Cell Carcinoma				
Squamous Cell Carcinoma				
Cancer of any type				

E. Since you began taking Viagra, Revatio, Cialis and/or Adcirca, have you experienced or been diagnosed or treated for any significant illnesses or disabilities (whether physical, psychiatric, or otherwise) *other than* those that you believe were caused by Viagra and/or Revatio and/or Cialis and/or Adcirca: **Yes ☐ No ☐**

If yes, please provide the following:

Injury or Condition	Date of Onset	Date of Diagnosis	Physician Who First Diagnosed Condition	Treating Healthcare Provider(s)	Medication / Treatment	Current Status of Condition

F. **Prescription and Non-Prescription History.** To the best of your recollection, list all medications, including prescription and non-prescription medications that you have taken for the past five (5) years, to the extent not already included in the medication information provided above in this Plaintiff Fact Sheet, provided for in the supplied medical records or pharmacy records:

Medication	Date First Taken	Date Last Taken	Prescribing Healthcare Provider(s) (if any)	Reason for Prescription / Use	Name and Address of Pharmacy Filled At

G. **Tobacco Use.** Fill in the blank applicable to your history of smoking and/or tobacco use over the last ten (10) years:

Type of Tobacco Used	Timeframe of Use (Start Date – End Date)	Currently Using? (Y/N)	Amount of Use (e.g. packs per day)

H. **Illicit Drugs/Controlled Substances.** Have you ever used (even one time) illicit drugs or controlled substances of any kind in the last five (5) years? **Yes ☐ No ☐**

If yes:

Substance	Dates of Use

VI. YOUR HEALTHCARE PROVIDERS

A. Please complete the following for your healthcare provider(s) for ten (10) years prior to your melanoma diagnosis at issue in this case to the present. Please include primary care physician(s), urologist(s) and cardiologist(s), and any other healthcare providers or hospital facilities not previously disclosed in this fact sheet.

Name	Address	Specialty

B. Have you seen any mental health professionals or counselors about your experiences with erectile dysfunction? Yes ☐ No ☐

If yes, please complete the following:

Name	Address	Dates Visited

C. **Insurance.** Identify each health insurance carrier/company which provided you with medical coverage and/or pharmacy benefits beginning five (5) years before your diagnosis with melanoma which was subsequent to your use of Viagra, Revatio, Cialis and/or Adcirca, including the identity of the named insured.

Carrier	Policy Number	Named Insured

VII. Fact Witnesses. Please identify all persons who you believe possess information concerning your injury and/or your current medical conditions and for each, state their name, address, telephone number, and a description of the information you believe they possess.

Name: _____
Address: _____
City: _____ State: _____ Zip:_____ Phone: _____
Relationship: _____
Information they possess: _____
_____

Name: _____
Address: _____
City: _____ State: _____ Zip:_____ Phone: _____
Relationship: _____
Information they possess: _____
_____

Name: _____
Address: _____
City: _____ State: _____ Zip:_____ Phone: _____
Relationship: _____
Information they possess: _____
_____

(Please copy and complete and attach additional pages if necessary to provide a complete response.)

VIII. DOCUMENTS

A. Please indicate if any of the following documents and things are currently in your possession, custody or control or in the possession, custody, or control of your lawyers, and if so, please attach a copy to this Fact Sheet:

1. Records of treating healthcare providers, hospitals, pharmacies, insurance and other healthcare providers identified in response to this fact sheet.

   Yes _____ No _____

2. Deceased person's death certificate (if applicable).

   Yes _____ No _____

3. Report of autopsy of deceased person (if applicable).

   Yes _____ No _____

B. **Authorizations** - Please sign and attach to this Fact Sheet the authorizations for the release of records appended hereto.

C. **Documents in your possession** - If you have any of the following materials in your custody, control or possession or in the possession, custody or control of your lawyers, please attach a copy to this Fact Sheet. This does not include privileged materials. If you do not have documents in your current possession to produce, please check the N/A box. This section recognizes that discovery is ongoing and shall be supplemented as new information becomes available.

1. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.
   N/A ☐

2. Copies of the entire packaging, including the bottle, box, and label for the Viagra, Revatio, Cialis and/or Adcirca you allege caused your injury and any remaining medication. (Plaintiff must maintain the originals of the items requested in this subpart.)
   N/A ☐

3. All written statements obtained from or given by any person having knowledge of facts relevant to the subject of this litigation. (Please do not create a new document to respond to this request.)
   N/A ☐

4. All documents relating to your purchase of Viagra, Revatio, Cialis and/or Adcirca, including, but not limited to, receipts, prescriptions, or records of purchase.
N/A ☐

5. All documents in your possession which you believe were provided to you (not to your lawyer) by Defendant(s).
N/A ☐

6. All photographs, drawings, slides or videos from two years prior to the diagnosis of melanoma until the present relating to Viagra, Revatio, Cialis and/or Adcirca, and/or the melanoma you allege Viagra, Revatio, Cialis and/or Adcirca caused.
N/A ☐

7. All entries in journals, diaries, notes, letters, emails, or other documents written by you relating to erectile dysfunction, pulmonary arterial hypertension, benign prostastic hyperplasia, your use of Viagra, Revatio, Cialis and/or Adcirca, and/or the injuries you allege Viagra, Revatio, Cialis and/or Adcirca caused.
N/A ☐

8. All documents you received from your healthcare provider(s) relating to erectile dysfunction, pulmonary arterial hypertension, benign prostastic hyperplasia, your use of Viagra, Revatio, Cialis and/or Adcirca, and/or the injuries you allege Viagra, Revatio, Cialis and/or Adcirca caused.
N/A ☐

9. All documents (including electronic data) relating to any web sites you have viewed, chat rooms, web logs (or "blogs"), electronic mail, or other Internet activity in which you have engaged related to your use of Viagra, Revatio, Cialis and/or Adcirca and/or the injuries you allege Viagra, Revatio, Cialis and/or Adcirca caused.
N/A ☐

10. All documents relating to any communication by you to or from the Food & Drug Administration ("FDA"), including but not limited to on-line, telephoned, mailed, or faxed communications to the FDA's MedWatch program, regarding Viagra, Revatio, Cialis and/or Adcirca, including the dates of such communications.
N/A ☐

11. If you claim you have suffered a loss of earnings or earning capacity, your federal tax returns for each year you are claiming a loss.
N/A ☐

12. If you claim any loss from medical expenses, copies of all bills from any treating healthcare provider, hospital, pharmacy or other healthcare provider.
N/A ☐

13. Copies of letters testamentary or letters of administration relating to your status as plaintiff (if applicable).
N/A ☐

VERIFICATION

I,_____, declare under penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Plaintiff's Fact Sheet is true, complete, and correct to the best of my knowledge, information, and belief, and that I have supplied all the documents requested in Part VIII of this Plaintiff's Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have signed and supplied the authorizations attached to this Verification.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in any material respect incomplete or incorrect.

_____ _____

Signature Date

EXHIBIT 2

Authorization and Release for Medical Records

Excluding Psychiatric, Psychological and Mental Health Treatment Providers/Notes/Records

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(Excluding Psychiatric, Psychological, and Mental Health Treatment Notes/Records)

(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Patient | Date of Birth | Social Security Number

This will authorize you to furnish copies of the following records and/or information:

* All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians.
* All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and catheterization reports.
* All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
* All billing records including all statements, itemized bills, and insurance records.

****Notwithstanding the broad scope of the above disclosure requests, the undersigned does not authorize the disclosure of notes or records pertaining to psychiatric, psychological, or mental health treatment or diagnosis as such terms are defined by HIPAA, 45 CFR §164.501**.

1. To my medical provider: **This authorization is being forwarded by, or on behalf of, attorneys for the defendants for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial**.
2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
3. Unless otherwise revoked, this authorization will expire in one year.
4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.
5. A notarized signature is not required. A copy of this authorization may be used in place of an original.
6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.
7. **I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that by signing this authorization I am agreeing that this protected information will be released.**

You are authorized to release the above records to the following representatives of defendants, who have agreed to pay reasonable charges made by you to supply copies of such records: **Litigation Management, Inc.; 6000 Parkland Boulevard; Mayfield Heights, OH 44124.**

Date:_____ _____
Patient/Representative Signature *[Print name if not Patient]*

EXHIBIT 3

Authorization and Release for Mental Health Records

To be executed ONLY if Plaintiff is asserting a claim for psychological injury or has identified a mental health provider or counselor on his or her PFS in response to relevant questions.

LIMITED AUTHORIZATION TO DISCLOSE PSYCHIATRIC, PSYCHOLOGICAL AND/OR MENTAL HEALTH TREATMENT NOTES/RECORDS

(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Patient | Date of Birth | Social Security Number

This will authorize you to furnish copies of the following records and/or information:

- All "psychotherapy notes", as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501. Under HIPAA, the term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's record. This authorization does **not** authorize ex parte communication concerning same.

1. To my medical provider: **This authorization is being forwarded by, or on behalf of, attorneys for the defendants for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial**.
2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
3. Unless otherwise revoked, this authorization will expire in one year.
4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.
5. A notarized signature is not required. A copy of this authorization may be used in place of an original.
6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.
7. **I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that by signing this authorization I am agreeing that this protected information will be released.**

You are authorized to release the above records to the following representatives of defendants, who have agreed to pay reasonable charges made by you to supply copies of such records: **Litigation Management, Inc.; 6000 Parkland Boulevard; Mayfield Heights, OH 44124.**

Date: _____ _____
Patient/Representative Signature *[Print name if not Patient]*

EXHIBIT 4

Authorization and Release of Employment Records

To be executed ONLY for specific Employer(s) for which Plaintiff is making a wage loss claim.

LIMITED AUTHORIZATION TO DISCLOSE
EMPLOYMENT AND WAGE RECORDS

To: _____
Name of Employer

_____
Address

_____
City, State and Zip Code

I authorize the limited disclosure of my personnel file for the purpose of review and evaluation in connection with a legal claim; copies of all applications for employment; resumes; records of all positions held; job descriptions of positions held; wage and income statements and/or compensation records; wage increases and decreases; evaluations, reviews and job performance summaries; W-2s; and correspondence or memoranda regarding the undersigned.

_____ _____ _____
Name of Employee Date of Birth Social Security Number

You are authorized to release the above records to the following representatives of defendants, who have agreed to pay reasonable charges made by you to supply copies of such records: **Litigation Management, Inc.; 6000 Parkland Boulevard; Mayfield Heights, OH 44124.**

This authorization does not authorize you to disclose anything other than documents and records to anyone. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. I

I acknowledge the right to revoke this authorization by writing to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. Any facsimile, copy or photocopy of this authorization shall authorize you to release the records herein with the same validity as if the original had been presented to you. Unless otherwise revoked, this authorization will expire in one year.

Date:_____ _____
Employee/Guardian/Personal Representative
Signature *[Print name if not Employee]*

EXHIBIT 5

Authorization and Release for Health Insurance Records

LIMITED AUTHORIZATION FOR RELEASE OF HEALTH INSURANCE RECORDS

(HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508)

To: _____

Name

_____

Address

_____

City, State and Zip Code

This will authorize you to furnish copies of any and all insurance claims applications and benefits, and all medical, health, hospital, physicians, nursing or allied health professional reports, records or notes, invoices and bills, in your possession that pertain to the named insured identified below.

_____ _____ _____

Name of Insured Date of Birth Social Security Number

You are authorized to release the above records to the following representatives of defendants, who have agreed to pay reasonable charges made by you to supply copies of such records: **Litigation Management, Inc.; 6000 Parkland Boulevard; Mayfield Heights, OH 44124.**

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you. Unless otherwise revoked, this authorization will expire in one year.

Date:_____ _____

Insured/Guardian/Personal Representative
Signature *[Print name if not Insured]*

EXHIBIT 6

Authorization and Release for Centers for Medicare and Medicaid

Medicare

Beneficiary Services: 1-800-MEDICARE (1-800-633-4227)
TTY/ TDD: 1-877-486-2048

This form is used to advise Medicare of the person or persons you have chosen to have access to your personal health information.

Where to Return Your Completed Authorization Forms:
After you complete and sign the authorization form, return it to the address below:

Medicare CCO, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

For New York Medicare Beneficiaries ONLY
The New York State Public Health Law protects information that reasonably could identify someone as having HIV symptoms or infection, and information regarding a person's contacts. Because of New York's laws protecting the privacy of information related to alcohol and drug abuse, mental health treatment, and HIV, there are special instructions for how you, as a New York resident, should complete this form.

- For question 2A, check the box for *Limited Information*, even if you want to authorize Medicare to release any and all of your personal health information.

- **Then proceed to question 2B.** You may also check any of the remaining boxes and include any additional limitations in the space provided. For example, you could write "payment information".

Instructions for Completing Section 2C of the Authorization Form:
Please select one of the following options.

- **Option 1** To **include** all information, check the box: "All information, including information about alcohol and drug abuse, mental health treatment, and HIV". Proceed with the rest of the form.

- **Option 2** To **exclude** the information listed above, check the box "Exclude information about alcohol and drug abuse, mental health treatment, and HIV". Then proceed with the rest of the form.

If you have any questions or need additional assistance, please feel free to call us at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Sincerely,

1-800-MEDICARE
Customer Service Representative

Encl.

Form Approved
OMB No. 0938-0930
Expiration Date: 6/30/2021

Information to Help You Fill Out the "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form

By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in the privacy notice contained in the Medicare & You handbook. You may take back ("revoke") your written permission at any time, except if Medicare has already acted based on your permission.

If you want 1-800-MEDICARE to give your personal health information to someone other than you, you need to let Medicare know in writing.

If you are requesting personal health information for a deceased beneficiary, please include a copy of the legal documentation which indicates your authority to make a request for information. (For example: Executor/Executrix papers, next of kin attested by court documents with a court stamp and a judge's signature, a Letter of Testamentary or Administration with a court stamp and judge's signature, or personal representative papers with a court stamp and judge's signature.) Also, please explain your relationship to the beneficiary.

Please use this step by step instruction sheet when completing your "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form. Be sure to complete all sections of the form to ensure timely processing.

1. Print the name of the person with Medicare.

Print the Medicare number exactly as it is shown on the red, white, and blue Medicare card.

Print the birthday in month, day, and year (mm/dd/yyyy) of the person with Medicare.

2. This section tells Medicare what personal health information to give out. Please check a box in 2A to indicate how much information Medicare can disclose. If you only want Medicare to give out limited information (for example, Medicare eligibility), also check the box(es) in 2B that apply to the type of information you want Medicare to give out. Box 2C must be completed by **New York Residents**.

3. This section tells Medicare when to start and/or when to stop giving out your personal health information. Check the box that applies and fill in dates, if necessary.

4. This section tells Medicare the reason for disclosure.

5. Medicare will give your personal health information to the person(s) or organization(s) you fill in here. You may fill in more than one person or organization.

If you designate an organization, you must also identify one or more individuals in that

Form Approved
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Expiration Date: 6/30/2021

organization to whom Medicare may disclose your personal health information.

6. The person with Medicare or personal representative must sign their name, fill in the date, and provide the phone number and address of the person with Medicare.

If you are a personal representative of the person with Medicare, check the box, provide your address and phone number, and attach a copy of the paperwork that shows you can act for that person (for example, Power of Attorney).

7. Send your completed, signed authorization to Medicare at the address shown here on your authorization form.

8. If you change your mind and don't want Medicare to give out your personal health information, write to the address shown under number seven on the authorization form and tell Medicare. Your letter will revoke your authorization and Medicare will no longer give out your personal health information (except for the personal health information Medicare has already given out based on your permission).

You should make a copy of your signed authorization for your records before mailing it to Medicare.

Form Approved
OMB No. 0938-0930
Expiration Date: 6/30/2021

1-800-MEDICARE Authorization to Disclose Personal Health Information

Use this form if you want 1-800-MEDICARE to give your personal health information to someone other than you.

1. **Print Name** (First and last name of the person with Medicare)	**Medicare Number** (Exactly as shown on the Medicare Card)	**Date of Birth** (mm/dd/yyyy)
_____	_____	_____

2. Medicare will only disclose the personal health information you want disclosed.

2A: Check only <u>one</u> box below to tell Medicare the specific personal health information you want disclosed:

- ☐ Limited Information (go to question 2b)
- ☐ Any Information (go to question 3)

2B: Complete <u>only</u> if you selected "limited information". Check all that apply:

- ☐ Information about your Medicare eligibility
- ☐ Information about your Medicare claims
- ☐ Information about plan enrollment (e.g. drug or MA Plan)
- ☐ Information about premium payments
- ☐ Other Specific Information (please write below; for example, payment information)

2C: NY Residents Only, this section must be completed.
Please select one of the following options: (Please check only one box.)

- ☐ Include all information. This includes information about alcohol and drug abuse, mental health treatment, and HIV.

OR

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☐ Exclude information about alcohol and drug abuse, mental health treatment, and HIV.

3. **Check only one box below indicating how long Medicare can use this authorization to disclose your personal health information** (subject to applicable law—for example, your State may limit how long Medicare may give out your personal health information):

☐ Disclose my personal health information indefinitely

☐ Disclose my personal health information for a specified period only

beginning: _____(mm/dd/yyyy) and ending: _____(mm/dd/yyyy)

4. **Fill in the reason for the disclosure (you may write "at my request"):**

This authorization is being forwarded by, or on behalf of, attorneys for the defendants for the purpose of litigation.

5. **Fill in the name and address of the person or organization to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person for any organization you list below. If you would like to authorize any additional individuals or organizations, please add those to the back of this form.**

Name Litigation Management, Inc.

Address 6000 Parkland Boulevard, Mayfield Heights, OH 44124

Name _____

Address _____

Form Approved
OMB No. 0938-0930
Expiration Date: 6/30/2021

Note: You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. To revoke authorization, send a written request to the address noted below. Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

6. **I authorize 1-800-MEDICARE to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.**

_____ _____ _____

Signature | Telephone Number | Date (mm/dd/yyyy)

Print the address of the person with Medicare (Street Address, City, State, and ZIP)

☐ Check here if you are signing as a personal representative and complete below.
Please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the person with Medicare signed above.

Print the Personal Representative's Address (Street Address, City, State, and ZIP)

Telephone Number of Personal Representative: _____

Personal Representative's Relationship to the Beneficiary: _____

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7. **Send the completed, signed authorization to**:

Medicare CCO, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

Print Form

Note: You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. If you would like to revoke authorization, send a written request to the address noted above.

Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0930. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

EXHIBIT 7

Authorization and Release for Workers' Compensation Records

To be executed ONLY if you have indicated a worker's compensation claim in the PFS

LIMITED AUTHORIZATION FOR RELEASE OF WORKERS' COMPENSATION RECORDS

(HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508)

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all workers' compensation records of any sort for any workers' compensation claims filed, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning:

_____	_____	_____
Name of Claimant	Date of Birth	Social Security Number

You are authorized to release the above records to the following representatives of defendants, who have agreed to pay reasonable charges made by you to supply copies of such records: **Litigation Management, Inc.; 6000 Parkland Boulevard; Mayfield Heights, OH 44124.**

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you. Unless otherwise revoked, this authorization will expire in one year.

Date:_____ _____

Claimant/Guardian/Personal Representative Signature *[Print name if not Claimant]*

EXHIBIT 8

Authorization and Release for Disability Claims Records

To be executed ONLY if you have indicated a disability claim in the PFS

LIMITED AUTHORIZATION FOR RELEASE OF DISABILITY CLAIMS RECORDS

(HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508)

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all records of disability claims of any sort for any disability claim(s) filed, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning:

_____	_____	_____
Name of Claimant	Date of Birth	Social Security Number

You are authorized to release the above records to the following representatives of defendants, who have agreed to pay reasonable charges made by you to supply copies of such records: **Litigation Management, Inc.; 6000 Parkland Boulevard; Mayfield Heights, OH 44124.**

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you. Unless otherwise revoked, this authorization will expire in one year.

Date: _____ _____

Claimant/Guardian/Personal Representative
Signature *[Print name if not Claimant]*